General Assembly **Substitute Bill No. 5451**

February Session, 2016 *____HB05451PH___032216___*

AN ACT CONCERNING THE DEPARTMENT OF PUBLIC HEALTH'S RECOMMENDATIONS FOR VARIOUS REVISIONS TO THE OFFICE OF HEALTH CARE ACCESS STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (a) of section 19a-486d of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) The commissioner shall deny an application filed pursuant to subsection (d) of section 19a-486a unless the commissioner finds that: (1) In a situation where the asset or operation to be transferred provides or has provided health care services to the uninsured or underinsured, the purchaser has made a commitment to provide health care to the uninsured and the underinsured; (2) in a situation where health care providers or insurers will be offered the opportunity to invest or own an interest in the purchaser or an entity related to the purchaser, safeguard procedures are in place to avoid a conflict of interest in patient referral; and (3) certificate of need authorization is justified in accordance with chapter 368z. The commissioner may contract with any person, including, but not limited to, financial or actuarial experts or consultants, or legal experts with the approval of the Attorney General, to assist in reviewing the completed application. The commissioner shall submit any bills for such contracts to the purchaser. Such bills shall not exceed one hundred fifty thousand

dollars. Upon the filing of an application pursuant to subsection (d) of section 19a-486a, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying bills submitted by the commissioner. The purchaser shall initially fund the escrow account with one hundred fifty thousand dollars. The **[**purchaser**]** escrow agent shall pay such bills **[**no**]** out of the escrow account directly to the expert or consultant not later than thirty days after the date of receipt of **[**such bills**]** each bill by the purchaser.

Sec. 2. Subsection (j) of section 19a-639f of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(j) The office shall retain an independent consultant with expertise on the economic analysis of the health care market and health care costs and prices to conduct each cost and market impact review, as described in this section. The office shall submit bills for such services to the purchaser, as defined in subsection (d) of section 19a-639. **[**Such purchaser**]** Upon the filing of an application involving the transfer of ownership of a hospital, the purchaser shall establish an escrow account pursuant to a formal escrow agreement provided by the Office of Health Care Access for the purpose of paying the bills for services provided by the independent consultant. The purchaser shall initially fund the escrow account with two hundred thousand dollars. The escrow agent shall pay such bills out of the escrow account directly to the independent consultant not later than thirty days after receipt of each bill by the purchaser. Such bills shall not exceed two hundred thousand dollars per application. The provisions of chapter 57, sections 4-212 to 4-219, inclusive, and section 4e-19 shall not apply to any agreement executed pursuant to this subsection.

Sec. 3. Subdivision (10) of subsection (a) of section 19a-638 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(10) The acquisition of computed tomography scanners, magnetic resonance imaging scanners, positron emission tomography scanners or positron emission tomography-computed tomography scanners, by any person, physician, provider, short-term acute care general hospital or children's hospital, except **[**(A)**]** as provided for in subdivision (22) of subsection (b) of this section; **[**, and (B) a certificate of need issued by the office shall not be required where such scanner is a replacement for a scanner that was previously acquired through certificate of need approval or a certificate of need determination;**]**

Sec. 4. Subdivision (18) of subsection (b) of section 19a-638 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(18) Replacement of existing imaging equipment with any other type of imaging equipment identified in subdivision (10) of subsection (a) of this section if such equipment was acquired through certificate of need approval or a certificate of need determination, provided a health care facility, provider, physician or person notifies the office of the date on which the equipment is replaced and the disposition of the replaced equipment;

Sec. 5. Subsection (d) of section 19a-638 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(d) The Commissioner of Public Health may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner holds a public hearing prior to implementing the policies and procedures and prints notice of intent to adopt regulations in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted. **[**Final regulations shall be adopted by December 31, 2011.**]**

Sec. 6. Subdivision (2) of subsection (j) of section 19a-508c of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(2) Such notice shall be worded to be general in nature and not specific to the individual patient and include the following information:

(A) A statement that the health care facility is now a hospital-based facility and is part of a hospital or health system;

(B) The name, business address and phone number of the hospital or health system that is the purchaser of the health care facility;

(C) A statement that the hospital-based facility bills, or is likely to bill, patients a facility fee that may be in addition to, and separate from, any professional fee billed by a health care provider at the hospital-based facility;

(D) (i) A statement that the patient's actual financial liability will depend on the professional medical services actually provided to the patient, and (ii) an explanation that the patient may incur financial liability that is greater than the patient would incur if the hospital-based facility were not a hospital-based facility;

(E) The estimated amount or range of amounts the hospital-based facility may bill for a facility fee or an example of the average facility fee billed at such hospital-based facility for the most common services provided at such hospital-based facility; and

(F) A statement that, prior to seeking services at such hospital-based facility, a patient covered by a health insurance policy should contact the patient's health insurer for additional information regarding the hospital-based facility fees, including the patient's potential financial liability, if any, for such fees.

Sec. 7. Subdivision (1) of subsection (l) of section 19a-508c of the

2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(l) (1) Each hospital, as defined in section 19a-646, and its affiliated health system shall report not later than July 1, 2016, and annually thereafter to the Commissioner of Public Health concerning facility fees charged or billed during the preceding calendar year. Such report shall include (A) the name and location of each facility owned or operated by the hospital or health system that provides services for which a facility fee is charged or billed, (B) the number of patient visits at each such facility for which a facility fee was charged or billed, (C) the number, total amount and range of allowable facility fees paid at each such facility by Medicare, Medicaid or under private insurance policies, (D) for each facility, the total amount of revenue received by the hospital or health system derived from facility fees, (E) the total amount of revenue received by the hospital or health system from all facilities derived from facility fees, (F) a description of the ten procedures or services that generated the greatest amount of facility fee revenue and, for each such procedure or service, the total amount of revenue received by the hospital or health system derived from facility fees, and (G) the top ten procedures for which facility fees are charged based on patient volume. For purposes of this subsection, "facility" means a hospital-based facility that is located outside a hospital campus.

Sec. 8. Subsections (g) to (i), inclusive, of section 19a-486i of the 2016 supplement to the general statutes are repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(g) Not later than **[**December 31, 2014**]** January 15, 2017, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing the activities of the group practices owned or affiliated with such hospital or hospital system. Such report shall include, for each such group practice: (1) A description of the nature of the relationship between the hospital or hospital system and the group

practice; (2) the names and specialties of each physician practicing medicine with the group practice; (3) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

(h) Not later than **[**December 31, 2014**]** January 15, 2017, and annually thereafter, each group practice comprised of thirty or more physicians that is not the subject of a report filed under subsection (g) of this section shall file with the Attorney General and the Commissioner of Public Health a written report concerning the group practice. Such report shall include, for each such group practice: (1) The names and specialties of each physician practicing medicine with the group practice; (2) the names of the business entities that provide services as part of the group practice and the address for each location where such services are provided; (3) a description of the services provided at each such location; and (4) the primary service area served by each such location.

(i) Not later than **[**December 31, 2015**]** January 15, 2017, and annually thereafter, each hospital and hospital system shall file with the Attorney General and the Commissioner of Public Health a written report describing each affiliation with another hospital or hospital system. Such report shall include: (1) The name and address of each party to the affiliation; (2) a description of the nature of the relationship among the parties to the affiliation; (3) the names of the business entities that provide services as part of the affiliation and the address for each location where such services are provided; (4) a description of the services provided at each such location; and (5) the primary service area served by each such location.

Sec. 9. Subsection (e) of section 19a-632 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) If any assessment is not paid when due, the commissioner shall impose a fee equal to (1) two per cent of the assessment if such failure to pay is for not more than **[**five**]** seven days, (2) five per cent of the assessment if such failure to pay is for more than **[**five**]** seven days but not more than fifteen days, or (3) ten per cent of the assessment if such failure to pay is for more than fifteen days. If a hospital fails to pay any assessment for more than thirty days after the date when due, the commissioner may, in addition to the fees imposed pursuant to this subsection, impose a civil penalty of up to one thousand dollars per day for each day past the initial thirty days that the assessment is not paid. Any civil penalty authorized by this subsection shall be imposed by the commissioner in accordance with subsections (b) to (e), inclusive, of section 19a-653.

Sec. 10. Subsection (e) of section 19a-632a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(e) Where any assessment is treated under subsection (d) of this section as an assessment not made in a timely manner because it is made by means other than electronic funds transfer, there shall be imposed a penalty equal to ten per cent of the assessment required to be made by electronic funds transfer. Where any assessment made by electronic funds transfer is treated under subsection (d) of this section as an assessment not made in a timely manner because the bank account designated by the department is not credited by electronic funds transfer for the amount of the assessment on or before the date such assessment is due, there shall be imposed a penalty equal to (1) two per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for not more than **[**five**]** seven days; (2) five per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by electronic funds transfer is for more than **[**five**]** seven days but not more than fifteen days; or (3) ten per cent of the assessment required to be made by electronic funds transfer, if such failure to pay by

electronic funds transfer is for more than fifteen days.

Sec. 11. Section 19a-634 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

[(a) The Office of Health Care Access shall conduct, on a biennial basis, a state-wide health care facility utilization study. Such study may include an assessment of: (1) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (3) other factors that the office deems pertinent to health care facility utilization. Not later than June thirtieth of the year in which the biennial study is conducted, the Commissioner of Public Health shall report, in accordance with section 11-4a, to the Governor and the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services on the findings of the study. Such report may also include the office's recommendations for addressing identified gaps in the provision of health care services and recommendations concerning a lack of access to health care services.**]**

[(b)**]** (a) The **[**office**]** Office of Health Care Access, in consultation with such other state agencies as the Commissioner of Public Health deems appropriate, shall establish and maintain a state-wide health care facilities and services plan. Such plan may include, but not be limited to: (1) An assessment of the availability of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (2) an evaluation of the unmet needs of persons at risk and vulnerable populations as determined by the commissioner; (3) a projection of future demand for health care services and the impact that technology may have on the demand, capacity or need for such services; and (4) recommendations for the expansion, reduction or modification of health care facilities or services. In the development of the plan, the office shall consider the recommendations of any advisory bodies which may be established by

the commissioner. The commissioner may also incorporate the recommendations of authoritative organizations whose mission is to promote policies based on best practices or evidence-based research. The state-wide health care facilities and services plan shall include a state-wide health care facility utilization study. Such study may include an assessment of: (A) Current availability and utilization of acute hospital care, hospital emergency care, specialty hospital care, outpatient surgical care, primary care and clinic care; (B) geographic areas and subpopulations that may be underserved or have reduced access to specific types of health care services; and (C) other factors that the office deems pertinent to health care facility utilization. The commissioner, in consultation with hospital representatives, shall develop a process that encourages hospitals to incorporate the state-wide health care facilities and services plan into hospital long-range planning and shall facilitate communication between appropriate state agencies concerning innovations or changes that may affect future health planning. The office shall update the state-wide health care facilities and services plan not less than once every two years.

[(c)**]** (b) For purposes of **[**conducting the state-wide health care facility utilization study and**]** preparing the state-wide health care facilities and services plan, that shall include the results of the state-wide healthcare facility utilization study, the office shall establish and maintain an inventory of all health care facilities, the equipment identified in subdivisions (9) and (10) of subsection (a) of section 19a-638, as amended by this act, and services in the state, including health care facilities that are exempt from certificate of need requirements under subsection (b) of section 19a-638, as amended by this act. The office **[**shall develop**]** may utilize an inventory questionnaire to obtain the following information: (1) The name and location of the facility; (2) the type of facility; (3) the hours of operation; (4) the type of services provided at that location; and (5) the total number of clients, treatments, patient visits, procedures performed or scans performed in a calendar year. The inventory shall be completed **[**biennially**]** every three years by health care facilities and providers and such health care

facilities and providers shall not be required to provide patient specific or financial data.

Sec. 12. Subsection (a) of section 19a-653 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(a) Any person or health care facility or institution that is required to file a certificate of need for any of the activities described in section 19a-638, as amended by this act, and any person or health care facility or institution that is required to file data or information under any public or special act or under this chapter or sections 19a-486 to 19a-486h, inclusive, or any regulation adopted or order issued under this chapter or said sections, which **[**wilfully**]** negligently fails to seek certificate of need approval for any of the activities described in section 19a-638, as amended by this act, or to so file within prescribed time periods, shall be subject to a civil penalty of up to one thousand dollars a day for each day such person or health care facility or institution conducts any of the described activities without certificate of need approval as required by section 19a-638, as amended by this act, or for each day such information is missing, incomplete or inaccurate. Any civil penalty authorized by this section shall be imposed by the Department of Public Health in accordance with subsections (b) to (e), inclusive, of this section.

Sec. 13. Subsection (c) of section 19a-654 of the 2016 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2016*):

(c) An outpatient surgical facility, as defined in section 19a-493b, a short-term acute care general or children's hospital, or a facility that provides outpatient surgical services as part of the outpatient surgery department of a short-term acute care hospital shall submit to the office the data identified in subsection **[**(c)**]** (b) of section 19a-634, as amended by this act. The office shall convene a working group consisting of representatives of outpatient surgical facilities, hospitals

and other individuals necessary to develop recommendations that address current obstacles to, and proposed requirements for, patient-identifiable data reporting in the outpatient setting. On or before February 1, 2012, the working group shall report, in accordance with the provisions of section 11-4a, on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and insurance and real estate. Additional reporting of outpatient data as the office deems necessary shall begin not later than July 1, 2015. On or before July 1, 2012, and annually thereafter, the Connecticut Association of Ambulatory Surgery Centers shall provide a progress report to the Department of Public Health, until such time as all ambulatory surgery centers are in full compliance with the implementation of systems that allow for the reporting of outpatient data as required by the commissioner. Until such additional reporting requirements take effect on July 1, 2015, the department may work with the Connecticut Association of Ambulatory Surgery Centers and the Connecticut Hospital Association on specific data reporting initiatives provided that no penalties shall be assessed under this chapter or any other provision of law with respect to the failure to submit such data.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2016*	19a-486d(a)
Sec. 2	*October 1, 2016*	19a-639f(j)
Sec. 3	*October 1, 2016*	19a-638(a)(10)
Sec. 4	*October 1, 2016*	19a-638(b)(18)
Sec. 5	*October 1, 2016*	19a-638(d)
Sec. 6	*October 1, 2016*	19a-508c(j)(2)
Sec. 7	*October 1, 2016*	19a-508c(l)(1)
Sec. 8	*October 1, 2016*	19a-486i(g) to (i)
Sec. 9	*October 1, 2016*	19a-632(e)
Sec. 10	*October 1, 2016*	19a-632a(e)
Sec. 11	*October 1, 2016*	19a-634
Sec. 12	*October 1, 2016*	19a-653(a)
Sec. 13	*October 1, 2016*	19a-654(c)

Statement of Legislative Commissioners:
Section 13 was added to change reference to "subsection (c) of section 19a-634" to "subsection (b) of section 19a-634" for statutory consistency.

PH *Joint Favorable Subst. -LCO*